

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-017949

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

4818

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED MAY 9 1963

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. | | c. CITY OR TOWN St. Louis | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1 | | d. STREET ADDRESS 2118 S. 11th | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ALBERT MAYBERRY | | 4. DATE OF DEATH Month Day Year 5/1/63 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 5/7/88 |
| 9. AGE (last birthday) 74 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator | | 11. BIRTHPLACE (City and state or country) Missouri |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | 12. CITIZEN OF WHAT COUNTRY USA |
| 13a. FATHER'S NAME F.M. Mayberry | | 13b. MOTHER'S MAIDEN NAME Nancy Donahue | |
| 14. NAME OF HUSBAND OR WIFE Birdie | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | |
| 16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY INSUFFICIENCY DUE TO (b) PULMONARY FIBROSIS - Emphysema DUE TO (c) CHRONIC BRONCHITIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CON PULMONARY MULTIPLE PEPTIC ULCERS PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 17. INFORMANT Birdie Mayberry, 2118 S. 11th, St. Louis, Mo. | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 50.20 | | 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20f. CITY, TOWN, OR LOCATION | | COUNTY STATE | |
| 21. I attended the deceased, from 4/19/63 to 5/1/63 and last saw her alive on 5/1/63 Death occurred at 10:00 P. on the date stated above, and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE (Degree or title) J.E. Dwyer M.D. | |
| 22b. ADDRESS 1515 LAFAYETTE AVE. | | 22c. DATE SIGNED 5/1/63 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 5/3/63 | |
| 23c. NAME OF CEMETERY OR CREMATORY Mt. Hope | | 23d. LOCATION (City, town, or county) St. Louis Co., Mo. | |
| 24. FUNERAL DIRECTOR McLaughlin, 2301 Lafayette, St. Louis, Mo. | | 25. DATE RECD. BY LOCAL REG. MAY 3 1963 | |
| 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | | | |

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

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T.E. BRITTINGHAM

USE BLACK INK

OR

TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4550

P. O. Address St. Francis, Md.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.